Is It An Emergency?

Dr. Jonathan Kotch: Hello and welcome to “Is It An Emergency?" presented by the Head Start National Center on Health. My name is Jonathan Kotch and I am a professor of maternal and child health at the Gillings School of Global Public Health of the University of North Carolina at Chapel Hill.

Head Start directors and teachers, health service managers, and others sometimes have to make a decision regarding whether to call emergency medical services or take a child to the emergency room. This presentation is aimed at providing some guidance for how to make that decision. In this presentation it is my intention to provide you with the knowledge and necessary understanding to describe the difference between children's emergent and urgent health care problems, list three reasons why a family should take their child to an emergency room rather than to their primary care provider, and develop one strategy used to influence a family's decision to take their child to the primary care provider rather than to the emergency room. Let's get started. There is a difference between an emergency and an urgent health problem that is not an emergency.

According to medical authorities, an emergent health problem is one that must be seen within 15 minutes or the child will suffer irreversible harm or death. On the other hand, urgent cases that are not emergencies must be seen within an hour. That is an urgent situation can wait 15 minutes but must be handled within an hour. A non-urgent case, which can wait an hour to be seen, may not need to go to the emergency room at all. On the other hand, even children who should be seen within 24 hours may need to go to the emergency room if their primary care provider is unable to accommodate them in that window of time. I realize that non-medical folks may find it difficult to make this distinction, but truly how many of us have been in a situation with a child who needed emergency care in 15 minutes or the child would suffer grave consequences? Fortunately not many. Here is a list of symptoms or conditions that warrant immediate medical attention.

Frankly most of these are common sense. Bleeding that won't stop, inability to breath, sudden change in level of alertness or consciousness, acute poisoning or serious head injury would look like an emergency to most of us. Chest pain is the kind of symptom more common among adults than children. But any severe, unrelenting pain anywhere in the body would be an emergency in an adult or child. There are some signs or symptoms that are emergent because the patient is an infant or a child. For example, any signs or symptoms of illness in an infant one month old or less, any fever over 104-degrees Fahrenheit in an infant three months old or less, or inconsolable crying, signs of possible meningitis, such as bulging fontanel, the soft spot in the center of an infant's head, stiff neck, high fever, or severe lethargy would be emergencies in an infant or a child while merely urgent in an adult. Unlike the signs and symptoms we have been talking about, here are some of the reasons why families actually bring their children to the emergency room.

Not every fever, rash, pain, or breathing problem is a true emergency to a medical provider, even if these may appear as such to a parent or caregiver. Other reasons parents take their children to the emergency room are a bump on the head, a nosebleed, minor trauma, or a swollen eye. If you add these percentages and those on the previous page, you get 101 percent. The number is more than 100

percent because of having to round up the percentages, which had decimals in the original. Clearly these complaints are even less urgent than those on the previous slide. Although you can imagine a parent or caregiver thinking that they need someone in the E. R. to tell them that. Families and physicians have different indicators of what constitutes a genuine emergency. Any fever might lead to a trip to the emergency room, but for a physician, the fever would have to be pretty high or the child would have to be three months old or less in order for it to be a true emergency. Parents may rush a child to the E. R. for a significant cut. But if that cut isn't bleeding uncontrollably, it isn't a medical emergency. Or a child may be so congested that the family considers that he or she is having a breathing problem, but that child would have to have bluish lips, tongue, or gums before an M.D. would call that an emergency. Caring for a sick child can be stressful for parents, especially if they are unsure whether their child's condition is severe or not. Although parents may know best when their child's behavior indicates that they are sick, many articles in medical journals have shown that parents' and physicians' perceptions of whether a child's condition requires urgent medical attention may differ. For example in this study that this table is from, for a group of parents who brought their children to the emergency room, 94 percent of those parents thought that the child's condition was urgent, but only 74 percent of physicians agreed with them. 27 percent of those children could've waited 24 hours to see the doctor. That relationship can also go the other way, however.

Of the 45 children whose parents thought they were non-urgent, the M.D.'s thought 14 of them, or 31 percent were in fact urgent cases. Some parental perceptions of when to take their children to the E.R. may be related to how many children they have. A recent article by Lemus, et al. in the Western Journal of Medicine reported that when parents brought groups of siblings to the emergency room, significantly fewer of them were judged by physicians to be in need of urgent care compared with children brought singly to the E.R.. The National Center on Health Statistics of the Centers for Disease Control and Prevention, also known as the CDC, surveys users of ambulatory care in the United States. In this case, parents of children four years old and under were surveyed. Children zero to four years of age are 10.5 percent of all emergency room users. As you can see, 45. 6 percent of infants and 51 percent of children zero to four years old who were in the emergency room were considered either semi-urgent or non-urgent cases. We have all heard the outgoing voicemail message when we call our medical care provider. If this is a medical emergency, please hang up and dial 911. That really doesn't help a parent determine if their child's condition is urgent or not. But it would make one think twice before one decides to please hold for an attendant. There are lots of reasons why children wind up in the emergency room, which are not strictly medical reasons.

These reflect some of the weaknesses in our current health care system. Primary care providers do not always satisfy their patients or their patients' parents. So if families have to wait a long time to see their primary care provider or they have communication problems with him or her, or they may be embarrassed because they missed a previous appointment, or they may think that the quality of care is better in the emergency room, then they may choose to go there rather than to the primary care provider even for a non-urgent condition. Similarly, the primary care provider is not always available 24/7 or the family may not know what a real emergency is or may simply want reassurance or additional

medical attention right now. So even if the child's condition is not urgent or emergent, that family may choose to go to the E.R..

Finally, it is often the case for Medicaid recipients that the assigned provider might not be easily accessible due to distance or transportation problems, leaving the E.R. as the more convenient and accessible alternative. But these are not good reasons to go to the E.R. and in fact inappropriate use of the E.R. can negatively affect the rest of us. Unnecessary use of the E.R. adds to the workloads of the medical providers there and adds to waiting times who really need emergent or urgent care. Unnecessary E.R. use can also delay admission for patients in need of in-hospital care. And it drives up the cost of care for everyone, even those who never use an emergency room. Even though some of the reasons parents and the caregivers bring children to the emergency room are inappropriate, their reasons are understandable and there are things that communities can do to reduce inappropriate use, starting with improving the quality, availability, and accessibility on primary care. Availability means that the services are there and accessibility means that they are being used by patients who need them. In some cases, families can benefit from consultation with social workers about some of the non-medical reasons they take their children to the E.R. when they could be served by community-based primary care physicians. Health managers can work with Medicaid providers in the community to help them understand their Medicaid clients better, to provide referral and follow-up and possibly interpreter services, and to be a liaison between the provider and the family to help assure that the family is able to make its appointments.

Other things that communities including Head Start and Early Head Start can do to reduce unnecessary emergency room use are to increase health literacy and help families overcome barriers to proper use of primary care. Health literacy is a focus of the Head Start National Health Center's Ariella Herman, whose work is cited here. In addition, linkages between health managers and primary care providers in the community could lead to strategies to increase the hours that primary care providers are available, to increase those preventive factors that could reduce health crises requiring a trip to the emergency room, and to make it easier to get an appointment when one is needed. Sometimes even doctors need to be reminded not to encourage their patients to use the E.R.. By increasing the quality of primary care, its timeliness, family-centeredness, availability, and access, we can reduce unnecessary use of the emergency room.

This is not something that Head Start can do alone, of course. But for all children, Head Start health managers can be part of the solution by partnering with medical providers and others in the community. There are many reasons already discussed in this presentation that help us understand why families choose the child health provider that they do. Head Start staff and in particular health managers should take the family-centered approach to help strengthen parents' appropriate choices. Families know their child best and they make the most choices about their child's health and health care. Given support and the right knowledge and skills, they can make the best choices. Families will be responsible for any health follow-up subsequent to the health care visit. Besides things like availability, cost, and quality, there may be historical or cultural reasons that parents prefer the emergency room. They may feel that others in the E.R. waiting room are their peers.

The E.R. staff may be of similar race or ethnicity. They may have gone there as a child themselves. Or there may be interpreters if English is not their first language. Help parents know that you and they are partners and that you value where they are coming from. We're ready to come to the end of my talk. I hope I have addressed the three objectives. Recall that an emergency needs to be taken care of in 15 minutes where as an urgent medical problem can be seen after 15 minutes but before an hour is up and that non-urgent cases can wait an hour or longer. Among the reasons to take a child to an emergency room would be if the child is choking or if breathing is so impaired that the child's lips, tongue, or gums are turning blue, if bleeding cannot be controlled, or if there is a fever over 104 degrees in a child three months of age or younger or 105 degrees Fahrenheit in any child, to name three reasons.

The third objective is something for you to do after we are done. What can you do to encourage families to use their primary care provider more often instead of the E.R.? Do all of your families have medical homes? A medical home can be a physician, nurse practitioner, or traditional healer. The Head Start Program Performance Standards require all Head Start programs to ensure that each child in Head Start has a medical home defined as a source of continuous, accessible, coordinated health care. Working with families and health care providers, Head Start staff can address the following barriers to regular access to a medical home: lack of information, transportation difficulties, the need for interpreters, cultural values and morals, inflexible work hours, lack of funds, fear of officials due to immigrant legal status and often marginalized status imposed by society, the unwillingness of providers to serve Head Start children, or scarce medical or dental resources in the community.

Programs can explore and exhaust ways to facilitate the provision of needed services such as providing after-hours care, obtaining medical advice by telephone, or providing on-site services as long as this is being done within the parameters of the Head Start Program Performance Standards.

Thank you for your kind attention and especially for all that you do every day for infants and children to keep them healthy and safe. Here is my contact information. Feel free to contact me if you have any questions. And here's the contact information for the Head Start National Center on Health in case you wish to contact them by phone or by email or visit our website on ECLKC. Thank you very much.